

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1963

Reg. Dist. No. 332

CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Salisbury</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Salisbury</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Peninsula General Hospital</i>		STREET ADDRESS <i>1301 N. Division St.</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>Harry</i>	(Middle) <i>Covington</i>	(Last) <i>Adkins</i>
4. DATE OF DEATH	(Month) <i>January</i>	(Day) <i>14</i>	(Year) <i>1951</i>
5. SEX	6. COLOR OR RACE <i>Male</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>White</i>	8. DATE OF BIRTH <i>Jan. 10 1886</i>
9. AGE last birthday yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retail lumberman</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY <i>G. S. A.</i>
13. FATHER'S NAME <i>Alpha Stanton Adkins.</i>	14. MOTHER'S MARRIED NAME <i>Henrietta Gilham</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>714-10-9173</i>
17. INFORMANT AND ADDRESS <i>Mrs. Velma L. Adkins</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
162x <i>Immediate cause</i>	(a) <i>Congestive Heart Failure</i>		
47c <i>Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</i>	(b) <i>Coronary Bronchitis</i>		
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>INJURY</i>	(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work m. Not While At work	HOW DID INJURY OCCUR? ADDRESS	
22. I hereby certify that I attended the deceased from <i>April 17, 1949</i> , to <i>Jan 14, 1951</i> , that I last saw the deceased alive on <i>Jan 14, 1951</i> , and that death occurred at <i>4:48 A.M.</i> , from the causes and on the date stated above. SIGNATURE <i>John H. Yeaman</i> (Degree or title) <i>M.D.</i> ADDRESS <i>238 Camden Ave. Salisbury, Md.</i> DATE SIGNED <i>1/14/51</i>			
23. BURIAL, Cremation Removal (Specify)	DATE THEREOF <i>1/16/51</i>	NAME OF CEMETERY OR CREMATORIAL <i>Peninsula Cemetery</i>	LOCATION (City, town, or county) (State) <i>Salisbury, Md.</i>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>	24. FUNERAL DIRECTOR ADDRESS <i>Dr. H. H. & Son</i>	
1-15-51		George C. Hall 950 306	



(Mr. W. B. Smith)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0962

CERTIFICATE OF DEATH

Reg. Dist. No.... 336

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE			
CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)		
4. SEX	COLOR OR RACE	5. S. MARRIED, WIDOWED, DIVORCED, (Specify)	6. DATE OF BIRTH		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.				
17. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		II. INFORMANT			
260 x Immediate cause	(a)	Cardiac Decomposition			
Antecedent cause(s)		Diabetes			
61 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	Nephritis			
III. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year)	(Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
INJURY	m.				
22. I hereby certify that I attended the deceased from 1-5: 1949, to 1-23, 1951, that I last saw the deceased alive on 1-20, 1951, and that death occurred at 12:35 P.M., from the causes and on the date stated above.					
SIGNATURE		ADDRESS		DATE SIGNED	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)	(State)
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
January 23, 1951		Harry G. Hudson	Walter P. Hollings		

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15



~~M~~
Evidence for addition
in #18 shown on:
FILM NO. G 130 JAN 17 1951

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0964

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH: COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Maryland</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Salisbury</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Snow Hill, Rural # 2</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Peninsula General Hospital</i>		STREET ADDRESS <i>(If rural, give location)</i>	
3. NAME OF DECEASED (Type or Print) <i>Rosa</i>	(First) <i>Rosa</i>	(Middle) <i>C</i>	(Last) <i>Ayers</i>
4. DATE OF DEATH <i>Aug 14 1951</i>	(Month) <i>Aug</i>	(Day) <i>14</i>	(Year) <i>1951</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Under</i>	8. DATE OF BIRTH <i>Aug 14 1936</i>
9. AGE last birthday yrs. <i>14</i>	10. KIND OF BUSINESS OR INDUSTRY <i>School</i>	11. BIRTHPLACE (State or foreign country) <i>Snow Hill, Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>Snow Hill, Md</i>
13. FATHER'S NAME <i>John Ayers</i>	14. MOTHER'S MAIDEN NAME <i>Annie James</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT AND ADDRESS <i>John Ayers Snow Hill, Md Rural #2</i>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p>Immediate cause (a) <i>Rheumatic Heart Disease</i></p> <p>Antecedent cause(s) (b) <i>Rheumatic Fever</i> - active at time of death. Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>58</i></p> <p>(c)</p>			
INTERVAL BETWEEN ONSET AND DEATH <i>6 weeks</i>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE <i>None</i>	(Specify) <i>PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY</i>	(CITY OR TOWN) <i>(CITY OR TOWN)</i>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>8 13 51 m.</i>		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <i>8 13 51 a.m.</i>
22. I hereby certify that I attended the deceased from <i>12/15</i> , 19 <i>50</i> , to <i>1-17-51</i> , 19 <i>51</i> , that I last saw the deceased alive on <i>1/6</i> , 19 <i>51</i> , and that death occurred at <i>8 13 51 a.m.</i> from the causes and on the date stated above. SIGNATURE <i>Fred R. Ayers</i> ADDRESS <i>Salisbury, Md</i> DATE SIGNED <i>1/6/51</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>None</i>	DATE THEREOF <i>Jan 9/51</i>	NAME OF CEMETERY OR CREMATORIAL <i>Layton Gates</i>	LOCATION (City, town or county) <i>Snow Hill, Md</i> (State) <i>(State)</i>
DATE REC'D BY LOCAL REG. <i>1-6-51</i>	REGISTRAR'S SIGNATURE <i>Mary W. Holleran</i>	24. FUNERAL DIRECTOR ADDRESS <i>Salisbury, Md</i>	



Evidence for change
Dr. Transen
of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

965

AM No. G 130 JAN 16 1951

CERTIFICATE OF DEATH

Reg. Dist. No. 532

1. PLACE OF DEATH. COUNTY Wicomico		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Salisbury		MARYLAND LENGTH OF STAY (in this place)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fruitland	
STREET ADDRESS R. D. # I		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) Albertie	(Middle)	(Last) Banks
4. DATE OF DEATH Jan. 4 1951	5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed
8. DATE OF BIRTH June 6-1882	9. AGE last birthday 69 yrs.	10. KIND OF BUSINESS OR INDUSTRY House Work	11. BIRTHPLACE (State or foreign country) Near Allen Md.
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Albert Brumbley	14. MOTHER'S MAIDEN NAME Emily Chatham	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS Mr. Albert T. Banks	18. MEDICAL CERTIFICATION Fruitland Md.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral Thrombosis 9 days

332X Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(b) Cerebral Arteriosclerosis 2 yrs.

61

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

Diabetes Mellitus

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
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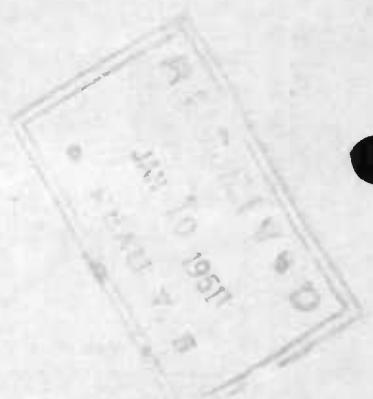
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Dec. 26, 1950, to Jan 4, 1951, that I last saw the deceased

alive on Jan 4, 1951, and that death occurred at 4:25 A. m., from the causes and on the date stated above.
SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Jan. 7-1951	NAME OF CEMETERY OR CREMATORIUM Banks Family Cemetery	LOCATION (City, town, or county) Near Fruitland Md.	(State)
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DATE REC'D BY LOCAL REG.	REG. 1-6-51	REGISTRAR'S SIGNATURE Mary W. Holloway	24. FUNERAL DIRECTOR Holloway & Company - Salisbury, Md.	ADDRESS
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age of 8 & 9 shown on:

Evidence for addition

MARYLAND STATE DEPARTMENT OF HEALTH

REG. NO. G 136 JAN 31 1951

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

0960

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <i>Caroline</i>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Md</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Salisbury</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Salisbury Md</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>none</i>		STREET ADDRESS <i>none</i>	
3. NAME OF DECEASED (Type or Print) <i>Sam</i>	(First) <i>Sam</i>	(Middle) <i></i>	(Last) <i>Beck</i>
4. DATE OF DEATH <i>1/14</i>	(Month) <i>1</i>	(Day) <i>14</i>	(Year) <i>1951</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Jan 1913</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mill hand</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	11. BIRTHPLACE (State or foreign country) <i>unknown</i>	12. CITIZEN OF WHAT COUNTRY? <i>unknown</i>
13. FATHER'S NAME <i>John Beck</i>	14. MOTHER'S MAIDEN NAME <i>unknown</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service) <i>168</i>	
16. SOCIAL SECURITY NO. <i>983-168</i>	17. INFORMANT <i></i>	18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause <i>Fractured Brain</i> Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>Fractured skull</i>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>none</i>			
19a. DATE OF OPERATION <i>none</i>	19b. MAJOR FINDINGS OF OPERATION <i></i>	20. AUTOPSY? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>Fractured Brain</i>	PLACE (Home, farm, factory, street, office bldg., etc.) <i>none</i>	(CITY OR TOWN) <i>Salisbury</i>	(COUNTY) <i>Caroline</i>
TIME (Month) OF INJURY <i>1/14</i>	(Day) <i>51</i>	(Year) <i>1951</i>	(STATE) <i>Md</i>
INJURY While at work <i>Not while</i>	INJURY OCCURRED at work <i>Not while</i>	HOW DID INJURY OCCUR? <i>struck on head by 2 x 4</i>	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input checked="" type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <i>John Beck</i>	(Degree or title) <i>None</i>	ADDRESS <i>Salisbury Md</i>	DATE SIGNED <i>1/14/51</i>
23. BURIAL Cremation REMOVAL (Specify) <i>none</i>	DATE THEREOF <i>1-24-51</i>	NAME OF CEMETERY OR CREMATORIAL <i>Caroline</i>	LOCATION (City, town, or county) <i>Salisbury</i>
DATE REC'D BY LOCAL REG. <i>1/23/51</i>	REGISTRAR'S SIGNATURE <i>Mary W. Holloway</i>	24. FUNERAL DIRECTOR <i>Zooper M. Beck</i>	ADDRESS <i>Salisbury Md. 69000</i>



MARGIN RESERVED FOR BINDING

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MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

6967

Reg. Dist. No. 335

1. PLACE OF DEATH COUNTY Wicomico			2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Sharptown			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sharptown		
HOSPITAL OR INSTITUTION OR STREET ADDRESS School St.			STREET ADDRESS School St.		
3. NAME OF DECEASED (Type or Print)		(First) CHARLOTTE	(Middle) ELIZABETH	(Last) BRADLEY	4. DATE OF DEATH Jan. 11 1951
5. SEX		6. COLOR OR RACE Female	7. SINGLE, MARRIED, WIDOWED, DIVORCED. Specify Widowed	8. DATE OF BIRTH July 24, 1869	9. AGE last birthday 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Alfred Twiford		14. MOTHER'S MAIDEN NAME Charlotte Wheaterly		12. CITIZEN OF WHAT COUNTRY U.S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Paul Ellis	
18. MEDICAL CERTIFICATION					

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN
ONSET AND DEATH

422.1 Immediate cause

Acute congestive heart failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause
stating the underlying cause last

(c)

Arterio-sclerotic cardio-vascular disease

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month)	(Day)	(Year)	INJURY OF INJURY	WHILE AT work <input type="checkbox"/> <input type="checkbox"/> at work	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes accident suicide homicide undetermined .

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THIS OF 1-16-51	NAME OF CEMETERY OR CREMATORIAL Firemans	LOCATION (City, town, or county) Sharptown	(State) Md.
DATE REC'D BY LOCAL REG. 1/16/51		REGISTRAR'S SIGNATURE Walter G. Mann	24. FUNERAL DIRECTOR Paul J. Smith		
ADDRESS Sharptown, Md.					



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MARYLAND STATE DEPARTMENT OF HEALTH

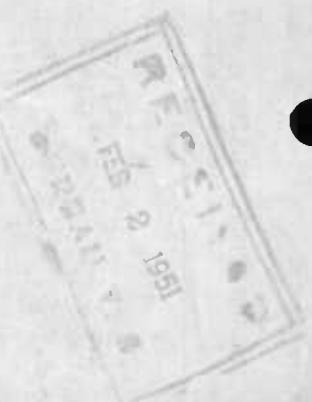
2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

4968

1. PLACE OF DEATH COUNTY WICOMICO		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE Maryland		COUNTY Worcester	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		STREET ADDRESS Berlin Branch Street	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital							
3. NAME OF DECEASED (Type or Print) Shumway		(First) (Middle) (Last) Shumway J Brittingham		4. DATE OF DEATH January 27 1951		(Month) (Day) (Year)	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, WIDOWED, DIVORCED. (Specify)		8. DATE OF BIRTH 12-19-44	9. AGE last birthday 6 yrs.	10. I under 1 year Months 6	11. I under 24 hrs. Days 6
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School child		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Peninsula Genl. Hospital Salisbury, Md.		12. CITIZEN OF WHAT COUNTRY? Salisbury, Md.	
13. FATHER'S NAME Shumway F. Brittingham		14. MOTHER'S MAIDEN NAME Evelyn Taylor		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT AND ADDRESS Shumway F. Brittingham, Berlin, Md.							
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 465a Immediate cause (a) Sub-acute myocarditis with congestive failure, etiology undetermined 2 mo. 93a Antecedent cause(s) (b) Sub-acute pericarditis unknown Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) Pulmonary infarct, right middle lobe cavitary							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 16 Jan 1951 to 27 Jan 1951 , that I last saw the deceased alive on 27 Jan 1951 , and that death occurred at 950 P.m. from the causes and on the date stated above.							
SIGNATURE Albert C. Kline, M.D.		(Degree or title) ADDRESS Salisbury, Md.		DATE SIGNED 28 Jan 1951			
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 1-31-51		NAME OF CEMETERY OR CREMATORIUM Evergreen Cemetery		LOCATION (City, town, or county) (State) Berlin, Worcester Co., Md.	
DATE REC'D BY LOCAL REG. 1-30-51		REGISTRAR'S SIGNATURE Mary W. Holloway		24. FUNERAL DIRECTOR B. Darkill		ADDRESS Salisbury, Md.	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

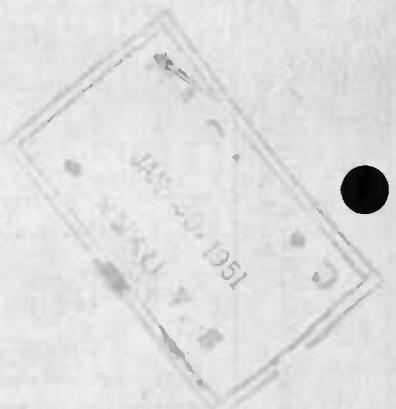
MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY Wicomico		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Salisbury		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital		STREET ADDRESS Route 4	
3. NAME OF DECEASED (Type or Print) Joseph		4. DATE OF DEATH January 22 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH May 30-1864 86 yrs.
10a. USUAL OCCUPATION (Give kind of work or description of working life, even if retired) Retired person		10b. KIND OF BUSINESS OR INDUSTRY tenant farmer	
11. BIRTHPLACE (State or foreign country) Wicomico Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Cannon		14. MOTHER'S MADDEN NAME Sarah Cannon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS Mr. Joseph W. Cannon (son)		18. MEDICAL CERTIFICATION 192 #83. John W. Sabby	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.1 Immediate cause (a) Cardiac decompensation 93d Antecedent cause(s) (b) Atherosclerotic C-V disease Disease or conditions, if any, giving rise to the above cause, stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
(CITY OR TOWN)		(COUNTY)	
(STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/> Not While Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 22, 1951, to Jan 22, 1951, that I last saw the deceased alive on Jan 22, 1951, and that death occurred at 9:15 A.M., from the causes and on the date stated above. SIGNATURE <i>William A. Gray</i> ADDRESS <i>Salisbury Md.</i> DATE SIGNED <i>1/25/51</i>			
23. BURIAL OR CREMATION REMOVAL (Specify) Jan. 25, 1951		DATE THEREOF NAME OF CEMETERY OR CREMATORIUM Parsons Cem.	
LOCATION (City, town, or county) Salisbury Md.		(State)	
DATE REC'D BY LOCAL REG. 1-24-51		REGISTRAR'S SIGNATURE Mary W. Holloway	
24. FUNERAL DIRECTOR ADDRESS Walter R. Holloway 1001 105			



Dr. Bramse

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 339

6970

339

1. PLACE OF DEATH COUNTY <i>McHenry</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Md.</i> COUNTY <i>McHenry</i>					
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Calumet</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Calumet</i>					
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>108 East Isabella st.</i>		STREET ADDRESS <i>(If rural) give location 112 East Isabella st.</i>					
3. NAME OF DECEASED (Type or Print) <i>Mary Adaline Chamberlin</i>	(First) <i>Mary</i> (Middle) <i>Adaline</i> (Last) <i>Chamberlin</i>	4. DATE OF DEATH <i>Jan 31 - 51</i>	(Month) (Day) (Year)				
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Jan 23 - 1875</i>	9. AGE last birthday <i>75 yrs.</i>	10. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	11. BIRTHPLACE (State or foreign country) <i>Tuscarora, Delaware Co., N.Y.</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		14. MOTHER'S MAIDEN NAME <i>Anna Bell Converse</i>					
13. FATHER'S NAME <i>Samuel Holland</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>17. INFORMANT Miss Arabelle Chamberlin</i>			

MARGIN RESERVED FOR BINDING

PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct
is especially important. Physicians: please write the causes of death clearly and legibly.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	19. C. MARSHAL ST. SALISBURY, MD.	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) _____	Cerebral Hemorrhage 12 hrs.		

331x	Immediate cause Antecedent cause(s)	(a) <u>arterial smokage</u>	19a
83a	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Arterio-sclerosis & hypertension</u>	
		(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?	
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) OF INJURY	(Day) (Year) (Hour)	INJURY OCCURRED While at Work m. Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1949, 19....., to Jan 31, 1951, that I last saw the deceased alive on Jan 31, 1951, and that death occurred at 650 P m., from the causes and on the date stated above.
SIGNATURE (Degree or title) ADDRESS DATE SIGNED

alive on January 1, 192, and that death occurred at 10:00 a.m. from the causes and on the date stated above.
SIGNATURE (Degree or title) ADDRESS DATE SIGNED

24. BURIAL/CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORIUM	LOCATION (City, town, or county)	(State)
	Feb. 3-51	Puritanian Cem.	Funerl Anne	MD.
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	ADDRESS
2-1-51	Mary W. Holloway		Holloway & C. Sabatay	MD.

DATE REC'D BY LOCAL REG. 2-1-57	REGISTRAR'S SIGNATURE Mary W. Holloway	24. FUNERAL DIRECTOR Holloway & C. Sabatay M.D. Walter R. Holloway	ADDRESS
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

0971

1. PLACE OF DEATH: COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Md</i> COUNTY <i>Baltimore</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Baltimore</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Baltimore</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>114 Bay St.</i>		STREET ADDRESS <i>114 Bay St.</i> (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <i>Margaret</i>	(Middle) <i></i>	(Last) <i>Cooper</i>
4. SEX <i>Female</i>	5. COLOR OR RACE <i>White</i>	6. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i></i>	7. DATE OF BIRTH <i>June 8-1873</i>
8. AGE last birthday 9. AGE last birthday If under 1 year Months. Days	10. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	11. BIRTHPLACE (State or foreign country) <i>Scotland</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
13. FATHER'S NAME <i>John Marshall</i>	14. MOTHER'S MAIDEN NAME <i>Jessie Allen</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i></i>	17. INFORMANT AND ADDRESS <i>Mrs. Lillian Parkway (daughter)</i>	18. MEDICAL CERTIFICATION <i>114 Bay St. Baltimore</i>
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause <i>Angostine Heart Failure</i>			
200 x Antecedent cause(s) <i>Diabetes Gangrene</i>			
61 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>Arteriosclerotic Heart Disease</i>			
21. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Diabetes Mellitus</i>			
22. DATE OF OPERATION <i></i>	19b. MAJOR FINDINGS OF OPERATION <i></i>		
23. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) <i></i> (COUNTY) <i></i> (STATE) <i></i>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at m. Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
24. I hereby certify that I attended the deceased from <i>Aug 20, 1949</i> , to <i>Jan 16, 1957</i> , that I last saw the deceased alive on <i>Jan 16, 1957</i> , and that death occurred at <i>12:15 a.m.</i> from the causes and on the date stated above.			
SIGNATURE <i>John H. Yaman M.D.</i>	(Degree or title) <i></i>		ADDRESS <i>238 Camber Ave. Sollshury, Md.</i> DATE SIGNED <i>1/16/57</i>
25. BURIAL, CREMATION REMOVAL (Specify) <i></i>	DATE <i>Jan - 20-51</i>	NAME OF CEMETERY OR CREMATORIAL <i>Northwood Cem.</i>	LOCATION (City, town, or county) <i>Plata</i> (State) <i>Md.</i>
DATE REC'D BY LOCAL REG. <i>1/16/51</i>	REGISTRAR'S SIGNATURE <i>Mary W. Holloway</i>	26. FUNERAL DIRECTOR ADDRESS <i>Holloway's Sollshury Md.</i>	
		Walter R. Holloway	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <i>Wicomico</i>			2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i>		
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)		COUNTY <i>Sussex</i>
TOWN <i>Sabiney</i>			TOWN <i>Baldie</i>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Peninsula Inn - Napt.</i>			STREET ADDRESS <i>300 S. Market St.</i>		
3. NAME OF DECEASED (Type or Print) <i>Ralph</i>			4. DATE OF DEATH <i>1/9 1951</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Jan. 14, 1880</i>	9. AGE last birthday <i>70</i>	10. months <i>1</i> yrs. <i>9</i>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Business Broker</i>			11. KIND OF BUSINESS OR INDUSTRY <i>Produce</i>		
13. FATHER'S NAME <i>James C. Bourne</i>			14. MOTHER'S MAIDEN NAME <i>Rosa Richardson</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>123-45-6789</i>		
17. INFORMANT AND ADDRESS <i>Mrs. Ethelma C. Prosser</i>					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause *Arterio-sclerotic Heart Disease & Hypertension*

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause
stating the underlying cause last *93d*

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN
ONSET AND DEATH

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *1/1/19*, 19*50*, to *1/8*, 19*51*, that I last saw the deceased alive on *1/5*, 19*51*, and that death occurred at *12:25* m., from the causes and on the date stated above.
SIGNATURE *Frederick P. Gramme M.D.* ADDRESS *Salisbury Md.* DATE SIGNED *1/1/51*

23. BURIAL, CREMATION REMOVAL (Specify)	DATE, TIME, OF REG. <i>1/1/51</i>	NAMES OF CEMETERY OR CREMATORIAL REG. <i>Wilson Cemetery & New Church</i>	LOCATION (City, town, or county) (State) <i>Wicomico Co.</i>
DATE REC'D BY LOCAL REG. <i>1/11/51</i>	REG. <i>Mary W. Holloway</i>	24. FUNERAL DIRECTOR REG. <i>George W. Johnson Co.</i>	ADDRESS <i>Burgess W. W. 290609</i>



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

Evidence for addition
in #18 shown on;

2411 N. Charles Street, Baltimore

0973

FILE NO. G 151 MAR 20 1954 CERTIFICATE OF DEATH

Reg. Dist. No.

22-

1. PLACE OF DEATH COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>MARYLAND</i> COUNTY <i>Wicomico</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <i>Salisbury</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Berlin</i>	
LENGTH OF STAY (in this place) <i>2 yrs.</i>		STREET ADDRESS <i>120 E. Main St., Berlin, Md.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Peninsula General Hospital</i>		(If rural, give location)	
3. NAME OF DECEASED (Type or Print) <i>Kennard, John</i>		4. DATE OF DEATH <i>January 12, 1951</i>	
(First) <i>Kennard</i> (Middle) <i>John</i> (Last) <i>Dennis</i>		(Month) <i>January</i> (Day) <i>12</i> (Year) <i>1951</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. SINGLE, MARRIED, WIDOWER, DIVORCED, (Specify) <i>Single</i>		8. DATE OF BIRTH <i>Aug 5, 1919</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		9. AGE last birthday <i>71 yrs.</i>	
10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Berlin, Md.</i>	
13. FATHER'S NAME <i>Lloyd W. Dennis</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
(If yes, give war or dates of service) <i>—</i>		17. INFORMANT AND ADDRESS <i>Mrs. Lloyd Dennis, Berlin, Md.</i>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
340.3 81a Immediate cause <i>acute meningitis, organism undetermined</i> (a) <i>(3/19/51 akc)</i> Antecedent cause(s) Diseases or conditions, if any, (b) giving rise to the above cause stating the underlying cause last (c)			
? 10 hrs.			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>INJURY</i>	
(CITY OR TOWN) <i>—</i>		(COUNTY) <i>—</i> (STATE) <i>—</i>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>4:00 A.M. - 8:00 A.M.</i>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>1/12</i> , 19 <i>51</i> , to <i>1/12</i> , 19 <i>51</i> , that I last saw the deceased alive on <i>1/12</i> , 19 <i>51</i> , and that death occurred at <i>5:20 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>J. Earl Turner M.D.</i> ADDRESS <i>Peninsula General Hosp. Berlin, Md.</i> DATE SIGNED <i>1/12/51</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>1/12/51</i> NAME OF CEMETERY OR CREMATORIAL <i>Evergreen</i> LOCATION (City, town, or county), (State) <i>Berlin, Md.</i>	
DATE REC'D BY LOCAL REG. <i>1-15-51</i>		REGISTRAR'S SIGNATURE <i>Mary W. Holloway</i> 24. FUNERAL DIRECTOR ADDRESS <i>—</i>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1974

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY Wicomico		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Salisbury		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Princess Anne	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital		STREET ADDRESS R.F.D.	
3. NAME OF DECEASED (Type or Print) Sadie	(First)	(Middle)	(Last)
4. DATE OF DEATH Jan. 19	(Month)	(Day)	(Year)
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Sent 6. 1883
9. AGE last birthday 67 yrs.	If under 1 year Months	If under 24 hrs. Days	If under 24 hrs. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Rufus Dryden		14. MOTHER'S MAIDEN NAME Ida Long Dryden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT AND ADDRESS Mr Bernard C. Dryden Jr. Anne, Md.		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN
ONSET AND DEATH

631x Immediate cause

(a) *Arteriosclerotic renal disease*
 131a Antecedent cause(s)
 Disease or conditions, if any, giving rise to the above cause
 stating the underlying cause last
 (b) *cystocell, renal*
 (c)

5 days

30 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

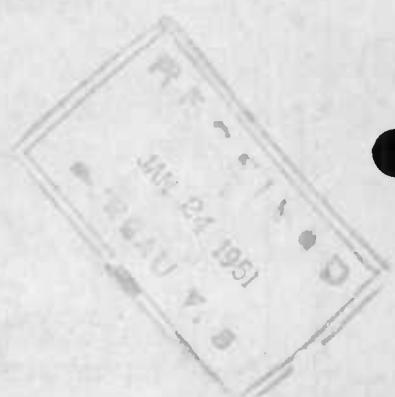
19a. DATE OF OPERATION 1-10-51	19b. MAJOR FINDINGS OF OPERATION <i>cystocell & renal</i>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED White at m. Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-7, 1951, to 1-19, 1951, that I last saw the deceased

alive on 1-18, 1951, and that death occurred at 116 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 1-21-1951	NAME OF CEMETERY OR CREMATORIUM St. Andrew Cemetery	LOCATION (City, town, or county) Princess Anne, Md.
DATE REC'D BY LOCAL REG. 1-20-51	REGISTRAR'S SIGNATURE Mary W. Holloway	24. FUNERAL DIRECTOR R. Wilson	ADDRESS
Princess Anne, Md.			



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1975

CERTIFICATE OF DEATH

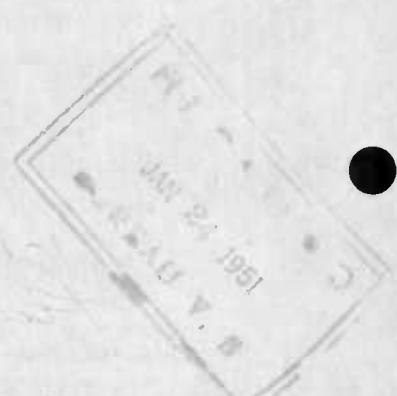
Reg. Dist. No. 332

1. PLACE OF DEATH: COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE	
Wicomico CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		LENGTH OF STAY (in this place)	
Camden & Pennsylvania Ave.		STREET ADDRESS	
3. NAME OF DECEASED (First) (Type or Print)		4. DATE OF DEATH (Last) (Month) (Day) (Year)	
SAMUEL S. FELDMAN		1 - 20 1957	
5. SEX Male		6. COLOR OR RACE White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH June 29, 1893	
9. AGE last birthday 68 yrs.		10. KIND OF BUSINESS OR INDUSTRY Retailer	
11. BIRTHPLACE (State or foreign country) Pottstown, Pa.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Jacob Feldman		14. MOTHER'S MAIDEN NAME Esther Turbush	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT AND ADDRESS Harry Miller, Virginia Ave. Salisbury		18. MEDICAL CERTIFICATION Pulmonary Embolism	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause 465 (a) _____		Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 111a (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While Work <input type="checkbox"/> At work <input type="checkbox"/> m. m. m.	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from , 1957, to , 1957, that I last saw the deceased alive on , 1957, and that death occurred at , 1957, from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED					
23. BURIAL/CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG.		REG. 1-20-51		Becky C. Holloway	Philadelphia Pa
REG. 1-20-51		REG. 1-20-51		24. FUNERAL DIRECTOR ADDRESS	George C. Kelly 290 658



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
CITY (If outside corporate limits, write RURAL and OR give nearest town)	LENGTH OF STAY (in this place)	TOWN	CITY (If outside corporate limits, write RURAL and give nearest town)
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
4. SEX	5. COLOR OR RACE	6. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	7. DATE OF BIRTH
M	M.D.C.	Single	11-9-33
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
None	None	Newark - Worcester, Md	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
George Tindley	Frances Marshall		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS	
None	None	Walter Tindley, Newark, Md, P.R.	
18. MEDICAL CERTIFICATION			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN
ONSET AND DEATHnearly
10 hours

916.0 Immediate cause (a) Burne nearly whole body
181 Antecedent cause(s) including dead septuaginties.

Diseases or conditions, if any, (b) giving rise to the above cause
stating the underlying cause last

(c)

Decedent was mentally deficient and
left in boxy alone day he was turned
over to his clothing caught fire.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
--	------------------------	----------------------------------	--------------

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
Accident		House	Newark	Worcester	Md
TIME (Month) (Day) (Year)	(Hour)	INJURY OCCURRED While at Work	HOW DID INJURY OCCUR?		
OF INJURY 1 9 1951 a.m.	11:30	Not While At work	Caught fire from bed to bed at a fire after death		

22. I hereby certify that I attended the deceased from	19	to	19	that I last saw the deceased	
alive on	19	and that death occurred at	9:15 P.m.	from the causes and on the date stated above.	
SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED		

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)	(State)
Burial	7-12-51	Evergreen Cemetery	Berlin, Worcester Co.	Md
DATE REC'D BY LOCAL REG.	REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-15-51	Mary W. Holloway	James B. Dashiel, Salisbury	Md.	1951



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Salisbury</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Salisbury</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Peninsula General Hospital</i>		STREET ADDRESS <i>Route 3</i>	
3. NAME OF DECEASED (Type or Print) <i>Hunter Mann Fitzgerald</i>	(First) <i>Hunter</i>	(Middle) <i>Mann</i>	(Last) <i>Fitzgerald</i>
4. DATE OF DEATH <i>January 14 1951</i>	(Month) <i>January</i>	(Day) <i>14</i>	(Year) <i>1951</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i></i>	8. DATE OF BIRTH <i>January 1, 1951</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i></i>	10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Roland Fitzgerald</i>	14. MOTHER'S MAIDEN NAME <i>Ethel Fitzgerald</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) <i></i>	16. SOCIAL SECURITY NO. <i></i>
17. INFORMANT AND ADDRESS <i>Roland Fitzgerald</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 762.5 Immediate cause 159 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (a) <i>Respiratory failure</i> (b) <i>Prematurity</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i> <i>14 days</i>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21. ACCIDENT SUICIDE HOMICIDE TIME (Month) (Day) (Year) (Hour) OF INJURY	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Jan. 2, 1951</i> , to <i>Jan. 14, 1951</i> , that I last saw the deceased alive on <i>Jan. 14, 1951</i> , and that death occurred at <i>3:40 A.m.</i> , from the causes and on the date stated above. SIGNATURE <i>William C. Morgan</i> (Degree or title) <i>m. D.</i> ADDRESS <i>Salisbury, Md.</i> DATE SIGNED <i>Jan. 14, 1951</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i></i>	DATE THEREOF <i>1/15/51</i>	NAME OF CEMETERY OR CREMATORIAL <i>Peninsula General Hospital</i>	LOCATION (City, town, or county) <i>Salisbury</i> (State) <i>Md</i>
DATE REC'D BY LOCAL REG. <i>1-15-51</i>	REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>	24. FUNERAL DIRECTOR <i>Peninsula General Hospital</i>	ADDRESS <i>Salisbury, Md.</i>



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 332

6975

1. PLACE OF DEATH COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		STREET ADDRESS	
TOWN Salisbury				TOWN Mardela		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS P. G. Hosp.							
3. NAME OF DECEASED Wm. Truitt (Type or Print)		(Last) Gillis		4. DATE OF DEATH Oct. 2. 1888		(Month) 62 (Day) 26 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married	8. DATE OF BIRTH Oct. 2. 1888	9. AGE last birthday 62 yrs.	If under 1 year Months 0	If under 24 hrs. Days 0	If under 24 hrs. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during Carpenter life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Builder		11. BIRTHPLACE (State or foreign country) Mardela Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Samuel Gillis		14. MOTHER'S MAIDEN NAME Elizabeth Brown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Wilson T. Gillis (Son)		18. MEDICAL CERTIFICATION Spring Hill Road, Salisbury, Md.	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause **420.1**

(a) **Coronary Occlusion**

Antecedent cause(s) **94a**

Diseases or conditions, if any, giving rise to the above cause
stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
OF INJURY	m.					

22. I certify that I took charge of the remains described above, new in Autopsy Inspection Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes accident suicide homicide undetermined .

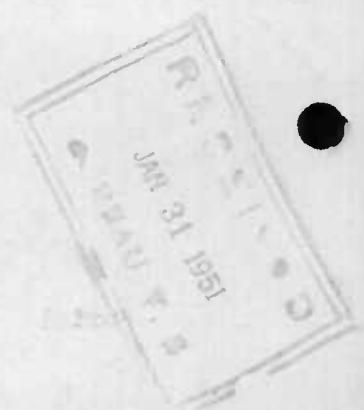
SIGNATURE *Edw L. Royer*

(Degree or title) **MD.**

ADDRESS **502 N. Division, Salisbury, Md.**

DATE SIGNED **1/26/51**

23. BURIAL, CREMATION RERIAL (Specify) Burial		DATE THEREOF Jan 29. 51.	NAME OF CEMETERY OR CREMATORIAL Mardela Cem.	LOCATION (City, town, or county) Mardela, Md.	(State)
DATE REC'D BY LOCAL REG. 1-29-51	REG.	REGISTRAR'S SIGNATURE Mary W. Holloway	24. FUNERAL DIRECTOR ADDRESS Holloway & Co., Salisbury, Md.		
			<i>Walter R. Holloway 510246</i>		



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH COUNTY CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS							
Wicomico MARYLAND Salisbury 2 yrs 3 mos Deer's Head State Hosp		Maryland COUNTY Brookview (If rural, give location)							
3. NAME OF DECEASED (Type or Print)	(First) Otha	(Middle)	(Last) Griffith						
4. DATE OF DEATH	Jan. 16	(Month)	(Day)						
5. SEX	6. COLOR OR RACE	7. SINGLED MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH	9. AGE last birthday	10. If under 1 year Months	11. If under 24 hrs Days	12. If under 24 hrs Hours	13. If Min.	
m	w		Feb. 27, 1874	76	yr.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY			
None		—		Maryland		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS	
John Griffith		Harriett B. Andrew		None		None		Hospital Record.	
18. MEDICAL CERTIFICATION									
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH									
<p>4501 Immediate cause (a) Myocardial infarction ~ 1.5 yrs</p> <p>94a Antecedent cause(s) (b) Coronary insufficiency ~ 1.5 yrs.</p> <p>Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) Arteriosclerosis General ~ 2 yrs.</p>									
<p>94a</p> <p>3) Agermia, secundaria</p> <p>6) Paroxysmal neoplasm of the lung?</p> <p>~ 1 year</p> <p>~ 1 year</p>									
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.									
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?					
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work m. Not While At work		HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from Sept. 1, 1949, to Jan. 16, 1951, that I last saw the deceased alive on Jan. 16, 1951, and that death occurred at 12:30 A.m., from the causes and on the date stated above.									
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED			
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIUM		LOCATION (City, town, or county) (State)			
Burial		Jan. 18, 1951		Brookview Cemetery		Brookview, Maryland			
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS			
1/17/51		Mary W. Hollingshead		J. F. Frampom		2nd Son, Federalsburg Md.			



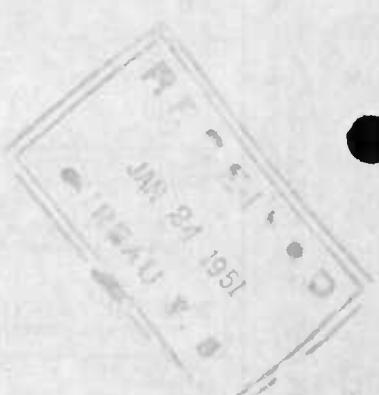
MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Md.</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Sabotury</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Sabotury</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>P. B. Hoyt.</i>		STREET ADDRESS <i>223 East Locust St</i>	
3. NAME OF DECEASED (Type or Print) <i>Henrietta</i>	(First) <i>Henrietta</i>	(Middle) <i></i>	(Last) <i>Hammond</i>
4. DATE OF DEATH <i>Jan. 19 - 19</i>	(Month) <i>Jan.</i>	(Day) <i>19</i>	(Year) <i>19</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i></i>	8. DATE OF BIRTH <i>Jan. 14-1857</i>
9. AGE last birthday yrs. <i>94</i>	10. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	11. BIRTHPLACE (State or foreign country) <i>Sabotury Md. U.S.A.</i>	12. CITIZEN OF WHAT COUNTRY? <i></i>
13. FATHER'S NAME <i>Sillette Parker</i>	14. MOTHER'S MAIDEN NAME <i>Hettie Middleton</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT AND ADDRESS <i>Virginia H. Pollitt Daughter</i>	
18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 94a	Immediate cause <i>coronary Insufficiency</i>	(a) <i></i>	
	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <i>Arteriosclerosis</i>	
		(c) <i>Arteriosclerotic gangrene of leg</i>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <i>1/16/57</i>	19b. MAJOR FINDINGS OF OPERATION <i>Arteriosclerotic gangrene of leg</i>		
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <i></i>	(CITY OR TOWN) <i></i>	(COUNTY) <i></i>
INJURY			(STATE) <i></i>
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>Jan. 16 1957</i>	INJURY OCCURRED While at Work <i>m.</i>	Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <i></i>
22. I hereby certify that I attended the deceased from <i>1/10</i> , 19 <i>51</i> , to <i>1/19</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>1/17</i> , 19 <i>57</i> , and that death occurred at <i>10 a.m.</i> from the causes and on the date stated above.			
SIGNATURE <i>Loreda Guyance M.A.</i>	(Degree or title) <i></i>	ADDRESS <i>Sabotury Md. 1/20/57</i>	DATE SIGNED
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial Jan. 21/51</i>	DATE THEREOF <i>Jan. 21/51</i>	NAME OF CEMETERY OR CREMATORIUM <i>Hammond</i>	LOCATION (City, town, or county) <i>R.R. Sabotury Md.</i>
DATE REC'D BY LOCAL REG. <i>1/20/51</i>	REG. <i>Mary W. Holloway</i>	REG. <i></i>	24. FUNERAL DIRECTOR ADDRESS <i>Walter R. Holloman</i>



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1981

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH- COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE	
Maryland		Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
P.S. Hospital		Ro # 2	
3. NAME OF DECEASED (Type or Print)	(First) <i>Edna</i>	(Middle) <i>Ellen</i>	(Last) <i>Watkins</i>
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Female	White	At Home	Oct. 24th 1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Md. Co. C. Md.	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
<i>Harley J. Parker</i>	<i>Nancy Jones</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT	
		<i>Mrs. Thomas Morris (dayle)</i>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p>Immediate cause (a) <i>Confederate Heart Disease</i></p> <p>Antecedent cause(s) (b) <i>Coronary Thrombosis</i></p> <p>94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)</p>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at m. Work	HOW DID INJURY OCCUR? Not White At work	
22. I hereby certify that I attended the deceased from <i>Jan 23, 1957</i> , to <i>Jan 23, 1957</i> that I last saw the deceased alive on <i>Jan 23, 1957</i> , and that death occurred at <i>5:30 p.m.</i> from the causes and on the date stated above.			
SIGNATURE <i>Carrie J. Bearn MD</i>	(Degree or title) <i>MD</i>	ADDRESS <i>203 W. Church St. Baltimore</i>	DATE SIGNED <i>1/26/57</i>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE <i>Jan. 29, 1957</i>	NAME OF CEMETERY OR CREMATORIUM <i>Arlon Cem.</i>	LOCATION (City, town, or county) <i>Baltimore</i>
VS. A15	DATE REC'D BY LOCAL REG. <i>1-26-57</i>	REGISTRAR'S SIGNATURE <i>Mary W. Holloway</i>	FUNERAL DIRECTOR <i>Walter R. Holloway</i>
			ADDRESS



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

6982

CERTIFICATE OF DEATH

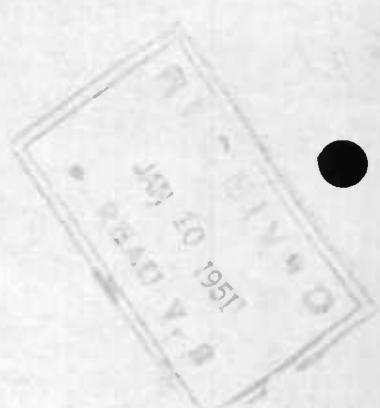
Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <u>Wicomico</u>		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>all life</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>903 Lake Street</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>	
3. NAME OF DECEASED (Type or Print) <u>Simon</u>		STREET ADDRESS <u>903 Lake Street</u>	
4. DATE OF DEATH <u>1 - 3 - 1954</u>		4. DATE OF DEATH <u>1 - 3 - 1954</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>aa</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>8-16-1884</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>merchant</u>		9. AGE last birthday <u>66 yrs.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>own store</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Wicomico Co. Md.</u>	
13. FATHER'S NAME <u>William Horsey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>no</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Ethel Horsey, 903 Lake St. Salisbury, Md.</u>		18. MEDICAL CERTIFICATION <u>Coronary Occlusion.</u> (?) <u>Arteriosclerotic Heart Disease.</u> (?)	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause <u>Coronary Occlusion.</u> (?)			
Antecedent cause(s) <u>Arteriosclerotic Heart Disease.</u> (?)			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>93d</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? <input type="checkbox"/> Yes <input type="checkbox"/> No			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
(CITY OR TOWN)		(COUNTY)	
(STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
m.		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 20, 1950</u> , to <u>Jan. 3, 1954</u> , that I last saw the deceased alive on <u>Jan. 3, 1951</u> , and that death occurred at <u>3:35 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE		(Degree or title) ADDRESS	
DATE SIGNED			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>1-7-51</u>	
NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county, State) <u>Green Acres Memorial Park</u>			
DATE REC'D BY LOCAL REG. <u>1-7-51</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holleray</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>James B. Dashiel 290649</u>	

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

1983
332
Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>MARYLAND</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Salisbury</i>		LENGTH OF STAY (In this place) <i>as per</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Car's Head Hosp.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>East New Market</i>	
STREET ADDRESS <i>None</i>		STREET ADDRESS <i>None</i>	
3. NAME OF DECEASED (First) <i>Fannie</i>		(Middle) <i>Virginia</i>	
(Last) <i>Jackson</i>		4. DATE OF DEATH <i>Jan 19</i>	
5. SEX <i>f</i>		6. COLOR OR RACE <i>W</i>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i></i>		8. DATE OF BIRTH <i>Jan 25 1879</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Brown</i>		14. MOTHER'S MAIDEN NAME <i>Amanda Dunn</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>unknown</i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT AND ADDRESS <i>Hospital Record</i>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
443x Immediate cause (a) <i>Arteriosclerotic Cardiovasc. disease with hypertension</i>			
Antecedent cause(s) (b) <i></i>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>93d</i>			
(c) <i>Arteriosclerosis, General</i>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death <i>Hypertrophic arthritis of spine</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE TIME (Month) (Day) (Year) (Hour) OF INJURY		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY While at Work <input type="checkbox"/> At work <input type="checkbox"/> m.	
(CITY OR TOWN)		(COUNTY)	
(STATE)		(STATE)	
22. I hereby certify that I attended the deceased from <i>Dec 5</i> , 1950, to <i>Jan 19</i> , 1951, that I last saw the deceased alive on <i>Jan 19</i> , 1951, and that death occurred at <i>8:15 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>Asaf A. Saar, M.D.</i> ADDRESS <i>Car's Head Hosp. Salisbury Md. 1/19/51</i> DATE SIGNED			
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>1/21/1951</i>	
NAME OF CEMETERY OR CREMATORIAL <i>East New Market Cemetery</i>		LOCATION (City, town, or county) (State) <i>East New Market, Md.</i>	
DATE REC'D BY LOCAL REG. <i>Jan 21, 1951</i>		REGISTRAR'S SIGNATURE <i>John M. Jr. M.D.</i>	
24. FUNERAL DIRECTOR ADDRESS <i>LeCompte Funeral Service,</i>		ADDRESS <i>Cambridge, Maryland</i>	
1-24-51 <i>Mary W. Holloway</i>			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

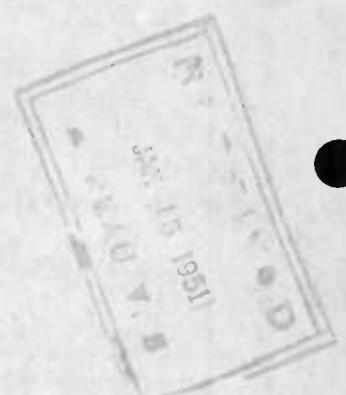
2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

6984

1. PLACE OF DEATH COUNTY <u>Wicomico</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place)	
TOWN <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>		TOWN <u>Ocean City</u>	
STREET ADDRESS		STREET ADDRESS <u>Bethel R.D.</u>	
3. NAME OF DECEASED (First) <u>Levin</u> (Middle) <u>Randall</u> (Last) <u>Jarmor</u>		4. DATE OF DEATH <u>January 6</u> 1957	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH <u>June 7, 1903</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home plant</u>	
11. BIRTHPLACE (State or foreign country) <u>Wilmington Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>Segunia Jarmor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>214-12-6948</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Levin Jarmor Berlin Md. 21801</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<u>415</u> <u>958</u> Immediate cause (a) <u>Myocardial Insufficiency</u> Antecedent cause(s) (b) <u>Rheumatic Heart Disease</u> Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) <u>Syphilitic</u> <u>3 yrs.</u> <u>3 yrs.</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/> Not While <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan. 6, 1957</u> , to <u>Jan. 6, 1957</u> , that I last saw the deceased alive on <u>Jan. 6, 1957</u> and that death occurred at <u>9:45 P.M.</u> from the causes and on the date stated above.			
SIGNATURE		(Degree or title) ADDRESS DATE SIGNED	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>1/9/51</u> NAME OF CEMETERY OR CREMATORIAL <u>Evanside</u> LOCATION (City, town, or county) <u>Bethel</u> (State) <u>Md R.D.</u>	
DATE REC'D BY LOCAL REG. <u>1-15-50</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u> 45	
24. FUNERAL DIRECTOR		ADDRESS <u>David J. Gilmore Esq. Salisbury Md. Jan 7 1957</u>	
		ADDRESS <u>970406</u>	



Dr. Rock

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
406 Tilghman St.		406 Tilghman St.	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
Male	White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Builder	Accomac Co. Va.	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
John Johnson	Helen Aydelotte		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, Unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.		
No			
17. INFORMANT			
Mrs. Philida Eller (Daughter)			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause 420.1	(a) Coronary Thrombosis	INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
Antecedent cause(s) 940	(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
	(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?	
		Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE TIME (Month) (Day) (Year) (Hour)	PLACE (Home, farm, factory, street, OF office hidg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
OF INJURY m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1/16, 1951, to 1/16, 1951, that I last saw the deceased alive on 1/16, 1951, and that death occurred at 5:30 p.m., from the causes and on the date stated above.			
SIGNATURE	ADDRESS	DATE SIGNED	
23. BURIAL/CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)
	Jan. 19-51	Accomac Mem. Park	Salisbury Md.
DATE REC'D BY LOCAL REG.	REG.	24. FUNERAL DIRECTOR	ADDRESS
1-19-51	Maryell Holloway	Walter R. Holloway	510246



Evidence for change
of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

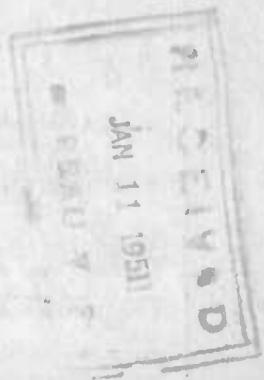
0986

FM No. G 130 JAN 16 1951

Reg. Dist. No. 332

CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY <u>Wicomico</u> STATE <u>MARYLAND</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>5 weeks</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula Inn. Shop.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>	
STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Type or Print)	(Middle)	(Last)	4. DATE (Month) (Day) (Year) OF DEATH / 5 1951
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>JAN. 1, 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Store Owner</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Benjamin Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Mary</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT AND ADDRESS <u>Mrs. Jessie O. Johnson</u>
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Arteriosclerosis & Hypertension</u>			
447 Antecedent cause(s) Diseases or conditions, if any, (b) <u>97</u> giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	While at m.	INJURY OCCURRED Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>12-14</u> , 19 <u>50</u> , to <u>1-5</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>1-5</u> , 19 <u>51</u> , and that death occurred at <u>5:15 P.M.</u> , from the causes and on the date stated above. SIGNATURE <u>Frank R. Grimes M.D.</u> ADDRESS <u>Salisbury, Md.</u> DATE SIGNED <u>1/8/51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1/8/51</u>	NAME OF CEMETERY OR CREMATORIAL <u>Salisbury Cem.</u>	LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u>
DATE REC'D BY LOCAL REG. <u>1-8-51</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	24. FUNERAL DIRECTOR <u>Dr. Grimes & Johnson</u>	ADDRESS <u>290116</u>



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Robbins

MARYLAND STATE DEPARTMENT OF HEALTH

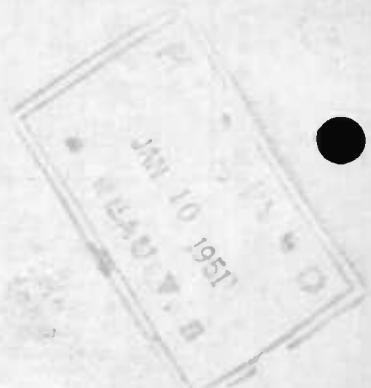
2411 N. Charles Street, Baltimore

0987

Reg. Dist. No. 332

CERTIFICATE OF DEATH

1. PLACE OF DEATH CITY Wicomico MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED CITY Maryland COUNTY Wicomico		
CITY (If outside corporate limits, write RURAL and OR give nearest town) Pittsville LENGTH OF STAY (in this place)			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pittsville		
HOSPITAL OR INSTITUTION OR STREET ADDRESS R. D. # 2			STREET ADDRESS R. D. # 2 (If rural, give location)		
3. NAME OF DECEASED (Type or Print) Annie P Jones			4. DATE OF DEATH Jan. 4 1951		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed	8. DATE OF BIRTH April 28-1877	9. AGE last birthday 33 yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife			10b. KIND OF BUSINESS OR INDUSTRY At Own Home	11. BIRTHPLACE (State or foreign country) Powellville Md.	
13. FATHER'S NAME Silas Bailey			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No			16. SOCIAL SECURITY NO.	14. MOTHER'S MAIDEN NAME Mary Hester Brittingham	
17. INFORMANT AND ADDRESS Mr. Roger Jones (SON)			18. MEDICAL CERTIFICATION R.D. # 2 Pittsville Md.		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
<p>422.2 Immediate cause (a) <i>Acute Cardiac Decompensation with Constrict 4 days</i></p> <p>93d Antecedent cause(s) (b) <i>as Chronic Syphilitic Myocarditis 3 yrs</i></p> <p>93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>Asthma Bronchiale Severe 15 yrs</i></p>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)			(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>3 Jan. 1951</i> , to <i>4 Jan. 1951</i> , that I last saw the deceased alive on <i>4 Jan. 1951</i> , and that death occurred at <i>1:15 A.m.</i> , from the causes and on the date stated above. SIGNATURE <i>Seaman A. Robbins M.D.</i> ADDRESS <i>5 Bay St. Berlin Md.</i> DATE SIGNED <i>1/5/51</i> (Degree or title)					
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Jan. 7 - 1951	NAME OF CEMETERY OR CREMATORIAL Mt. Pleasant Cem.	LOCATION (City, town, or county) (State) Near Powellville Md.		
DATE REC'D BY LOCAL REG. 1-6-51	REGISTRAR'S SIGNATURE <i>Mary W. Holloway</i>	24. FUNERAL DIRECTOR Holloway & Company - Salisbury, Md.			ADDRESS <i>Walter R. Holloway</i>



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6988

1. PLACE OF DEATH COUNTY Wicomico		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Head of the Creek		LENGTH OF STAY (in this place) all life	
HOSPITAL OR INSTITUTION OR STREET ADDRESS at home		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Head of the Creek	
3. NAME OF DECEASED (Type or Print) William		STREET ADDRESS Quantico, Md. Rt. #1	
(First) (Middle)		(Last)	
4. DATE OF DEATH January 23 1951		(Month) (Day) (Year)	
5. SEX Male	6. COLOR OR RACE AA	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 8910-1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		9. AGE last birthday If under 1 year Months 5 Days 13 Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Head of the Creek, Wic. Co. USA	
13. FATHER'S NAME unknown		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT AND ADDRESS Mrs. Mabel M. Waters, Quantico, Md. Rt. #1		18. MEDICAL CERTIFICATION	
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			

Immediate cause (a) Cerebral hemorrhage

INTERVAL BETWEEN
ONSET AND DEATH
4 days33IX
Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause
stating the underlying cause last
83a

(b) (c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Montb) OF INJURY	(Day) (Year) (Hour) m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan 20, 1951, to Jan 23, 1951, that I last saw the deceased
alive on Jan 22, 1951, and that death occurred at 11:50 p.m., from the causes and on the date stated above.
SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Hilma E. Enrich M.D. 1/25/51

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 1-26-51	NAME OF CEMETERY OR CREMATORIAL St. James Cem.	LOCATION (City, town, or county) Head of the Creek, Wic. Co. Md.	(State)
DATE REC'D BY LOCAL REG. 1-26-51	REGISTRAR'S SIGNATURE Mary W. Followay	24. FUNERAL DIRECTOR James B. Dashiell, Salisbury, Md.		
ADDRESS James B. Dashiell 100105				

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-29-51

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. *1 be correct age*
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Salisbury</i>		LENGTH OF STAY (in this place)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Peninsula General Hospital</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Tulsa</i>	
3. NAME OF DECEASED (Type or Print) <i>George Edwin Joyce</i>		4. DATE OF DEATH <i>January 12 1957</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH <i>1-12-51</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>Welles Jeannette Joyce</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p>776x Immediate cause (a) <i>prematurity</i></p> <p>159 Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</p> <p>(c)</p>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1/10/57</i> , 1957, to <i>1/12</i> , 1957, that I last saw the deceased alive on <i>1/11</i> , 1957, and that death occurred at <i>11:55 P.M.</i> from the causes and on the date stated above. SIGNATURE <i>1. Earl Farmer M.D.</i> ADDRESS <i>Peninsula Gen. Hospital</i> DATE SIGNED <i>1-13-57</i>			
23. BURIAL, CREMATION REMOVAL (Specify) REG.		DATE THEREOF <i>1/13/51</i>	
NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) <i>Peninsula General Hospital</i>		(State) <i>Salisbury, Md.</i>	
DATE REC'D BY LOCAL REG. <i>1-15-57</i>		REGISTRAR'S SIGNATURE <i>Maryell Holloway</i>	
24. FUNERAL DIRECTOR ADDRESS <i>Peninsula General Hospital</i>			
201121183 3872		Salisbury Md -	



Evidence for change in MARYLAND STATE DEPARTMENT OF HEALTH

8 shown on:

2411 N. Charles Street, Baltimore

180

1931

FILE NO. G 150 JAN 19 1951 CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH: COUNTY <u>Wicomico</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>25 days</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hosp</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
STREET ADDRESS <u>1412 S. Hanover Street</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Joseph</u>	(First)	(Middle)	(Last) <u>Kamp</u>
4. DATE OF DEATH <u>Jan. 13</u>	(Month) <u>Jan.</u>	(Day) <u>13</u>	(Year) <u>1951</u>
5. SEX <u>m.</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Sept. 7, 1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13. FATHER'S NAME <u>Joseph Kamp</u>	14. MOTHER'S MAIDEN NAME <u>Unknown</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>	16. SOCIAL SECURITY NO. <u>none</u>
17. INFORMANT AND ADDRESS <u>Hospital Record</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 163x Immediate cause <u>Carcinoma of the lung</u> 47d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>(b)</u> <u>(c)</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Secondary anemia</u>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	INTERVAL BETWEEN ONSET AND DEATH <u>~2.5 mo.</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec. 19</u> , 1950, to <u>Jan. 13</u> , 1951, that I last saw the deceased alive on <u>Jan. 13</u> , 1951, and that death occurred at <u>1:30 A</u> m., from the causes and on the date stated above. SIGNATURE <u>Axel A. Paar M.D.</u> ADDRESS <u>Deer's Head State Hosp. Salisbury, Md.</u> DATE SIGNED <u>1/13/51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Jan. 16, 1951</u>	NAME OF CEMETERY OR CREMATORIAL <u>Glen Haven</u>	LOCATION (City, town, or County) (State) <u>Baltimore</u> <u>md.</u>
DATE REC'D BY LOCAL REG. <u>1-15-51</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	24. FUNERAL DIRECTOR <u>The Hill & Johnson Co.</u>	ADDRESS <u>George C. Hill Jr. 6908 NW</u>



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

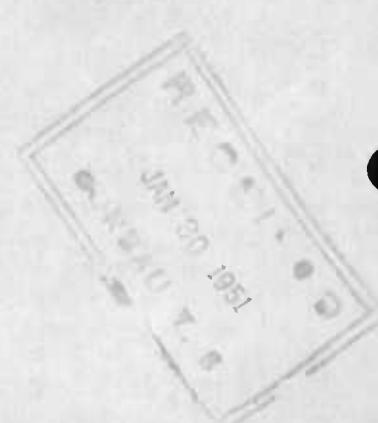
MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 336

1. PLACE OF DEATH COUNTY <u>Wicomico</u>			2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>MD</u> COUNTY <u>Wicomico</u>		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>DELMAR</u>			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>MARDEKA SPRINGS</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>FRIENDLY NURSING Home</u>			STREET (If rural, give location) ADDRESS		
3. NAME OF DECEASED (Type or Print)	(First) <u>BERTIE</u>	(Middle) <u>ELLEN</u>	(Last) <u>LLOYD</u>	4. DATE OF DEATH	(Month) <u>25</u> (Year) <u>1951</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>OCT 16 1866</u>	9. AGE last birthday yrs. <u>84</u>	If under 1 year Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>MD</u>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>John Heeseman</u>			14. MOTHER'S MAIDEN NAME <u>Phallie Ann Brown</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT AND ADDRESS <u>Mrs Thomas Shockley</u>	18. MEDICAL CERTIFICATION <u>Acute Congestive Cardiac Failure</u> <u>2 days</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.2</u> Immediate cause <u>Antecedent cause(s)</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>131.0</u>			(a) <u>Chronic Myocarditis</u> <u>3.75</u>	(b) <u>Chronic Hepatitis</u> <u>2 yrs</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) <u>(CITY OR TOWN)</u> (COUNTY) <u>(COUNTY)</u> (STATE) <u>(STATE)</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at m. Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR? ADDRESS	
22. I hereby certify that I attended the deceased from <u>Jan 1, 1961</u> , to <u>Jan 24, 1961</u> , that I last saw the deceased alive on <u>Jan 24, 1961</u> , and that death occurred at <u>12:30</u> p.m., from the causes and on the date stated above. SIGNATURE <u>H. E. Hudson</u> (Degree or title) <u>Notary Public</u> DATE SIGNED <u>1-26-51</u>					
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>1/28/51</u>		NAME OF CEMETERY OR CREMATORIAL <u>Bethel Cemetery</u> LOCATION (City, town, or county) <u>Wardella</u> (State) <u>MD</u>	
DATE REC'D BY LOCAL REG. <u>January 28, 51</u>		REGISTRAR'S SIGNATURE <u>Harry E. Hudson</u>		24. FUNERAL DIRECTOR ADDRESS <u>Paul J. Smith, Shapton, Md</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH CITY TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place)		2. USUAL RESIDENCE (HOME) OF DECEASED STATE CITY (If outside corporate limits, write RURAL and give nearest town) TOWN STREET ADDRESS	
Robert Ball and Mother		Milton		Matchine	
3. NAME OF DECEASED (Type or Print)	(Middle)	(Last)	4. DATE OF DEATH		(Month) (Day) (Year)
Male	White	Matchine	Feb. 8- 1876	74	January 14 1951
10. USUAL OCCUPATION (Give kind of work or working man, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH-PLACE (State or foreign country)	
Robert Ball and Mother		Salter Mill Weston Maryland		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no.)		16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME	
No				Sarah Elizabeth Foster	
18. MEDICAL CERTIFICATION					
351 New York Ave Salisbury Md.					
INTERVAL BETWEEN ONSET AND DEATH					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
445X Immediate cause (a) Extra-cranial hemorrhage					
93d Antecedent cause(s) (b) Hypertension C.V. disease					
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work m. Not While At work		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1/12, 1951, to 1/14, 1951, that I last saw the deceased alive on 1/14, 1951, and that death occurred at 8 P.m., from the causes and on the date stated above.					
SIGNATURE (Degree or title) ADDRESS DATE SIGNED					
23. BURIAL CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIUM	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		LOCATION (City, town, & county) (State)	
1/15/51		Mary D. Holloway		24. FUNERAL DIRECTOR ADDRESS	
M. D. Holloway		M. D. Holloway		Holloman & Co. Salter Md.	
M. D. Holloway		M. D. Holloway		M. D. Holloway 970307	



MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

0993

Reg. Dist. No. 331

1. PLACE OF DEATH
CITY (If outside corporate limits, write RURAL and
OR give nearest town)
TOWN

Wisconsin

MARYLAND

CITY (If outside corporate limits, write RURAL and LENGTH OF STAY
OR give nearest town) (In this place)HOSPITAL OR
INSTITUTION OR
STREET ADDRESS3. NAME OF
DECEASED
(Type or Print)

Steven

(Middle)

Miller

(Last)

4. DATE
OF
DEATHJan. 8th 1951

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED.
(Specify)

Married

8. DATE OF BIRTH

Oct. 10, 1889

9. AGE last birthday
If under 1 year
Months Days Hours
yrs. Months Days Hours
Min.10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)10b. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of
service)

16. SOCIAL SECURITY NO.

17. INFORMANT

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

910.3 Immediate cause

186-b Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause

stating the underlying cause last

(a) Fracture of Cervical Vertebra

(b) Sudden

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not

related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No 21. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.22. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry thereon and from the evidence

obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted

from: natural causes accident suicide homicide undetermined

SIGNATURE (Degree or title)

ADDRESS

DATE SIGNED

Oscar G. Fischer M.D. 300 N. Division St. Salisbury, Md. 1/8/51

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORIAL

LOCATION (City, town, or county)

(State)

Burial

1-11-1951

Parson Cemetery

Salisbury, Md.

Princess Anne, Md.

DATE REC'D BY LOCAL REG. 1-11-51

Mrs Mary Holloway



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <u>Wicomico</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Nebron</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Nebron</u>	
3. HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>William</u>		4. LENGTH OF STAY (in this place) <u>Myrs.</u>	
5. NAME OF DECEASED (First) <u>WILLIAM</u>		(Middle) <u>HENRY</u>	
(Type or Print) <u>WILLIAM</u>		(Last) <u>Mitchell, Jr.</u>	
6. SEX <u>Male</u>		7. COLOR OR RACE <u>White</u>	
8. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cookman</u>		9. 10b. KIND OF BUSINESS OR INDUSTRY <u>Canning factory</u>	
11. 13. FATHER'S NAME <u>William W. Mitchell</u>		12. 14. MOTHER'S MAIDEN NAME <u>Silvie Phillips</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>160</u>	
17. INFORMANT AND ADDRESS <u>Frank Mitchell</u>		18. MEDICAL CERTIFICATION <u>Cerebral Hemorrhage</u>	
19. I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331x Immediate cause (a) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
Antecedent cause(s) Diseases or conditions, if any, (b) <u>Arteriosclerosis</u> giving rise to the above cause stating the underlying cause last <u>Hypertension</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/> Not While Work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan. 16, 1951</u> , to <u>Jan. 16, 1951</u> , that I last saw the deceased alive on <u>Jan. 16, 1951</u> , and that death occurred at <u>1:45 A.M.</u> , from the causes and on the date stated above. SIGNATURE <u>William E. Eunice, M.D.</u> ADDRESS <u>Belvoir - Md.</u> DATE SIGNED <u>Jan. 16, 1951</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>1/18/51</u>	
DATE REC'D BY LOCAL REG. <u>1-17-51</u>		NAME OF CEMETERY OR CREMATORIAL <u>Parsons Cemetery</u>	
REG. <u>Mary W. Holloway</u>		LOCATION (City, town, or county) <u>Salisbury, Md.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>The Hill - Johnson & George C. Hill & 523408</u>			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

6995

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY Wicomico			2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Wicomico		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Salisbury			LENGTH OF STAY (in this place) 11 days		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital			CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Delmar		
3. NAME OF DECEASED (Type or Print) Craig Lynn			4. DATE OF DEATH January 31 1951		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH Jan. 20, 1951	9. AGE last birthday If under 1 year Months 11 Days 11 Hours 11 yrs.	10. BIRTHPLACE (State or foreign country) Salisbury, Maryland
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant			11. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME Malcolm T. Northrup			14. MOTHER'S MAIDEN NAME Virginia Irene Butler		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		
17. INFORMANT AND ADDRESS Malcolm T. Northrup, Delmar, Md.			18. MEDICAL CERTIFICATION		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 754.5 157-9 Immediate cause (a) Coarctation of the aorta (infantile type) congenital Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 157-9 (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION Patent intra-ventricular septal defect congenital					
21. ACCIDENT SUICIDE HOMICIDE			PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		
TIME (Month) OF INJURY	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? ADDRESS
22. I hereby certify that I attended the deceased from Jan 30, 1951, to Jan 31, 1951, that I last saw the deceased alive on Jan 31, 1951, and that death occurred at 5:05 P.m., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED Albert W. Hines, M.D. Salisbury, Maryland 1st Feb '51					
23. BURIAL, CREMATION REMOVAL (Specify) Burial			DATE THEREOF Feb. 2, 1951		
DATE REC'D BY LOCAL REG. 2-8-51			REGISTRAR'S SIGNATURE Mary W. Holloway		
NAME OF CEMETERY OR CREMATORIAL Washington Cemetery			LOCATION (City, town, or county) (State) Near Hurlock, Maryland		
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Md.			ADDRESS		



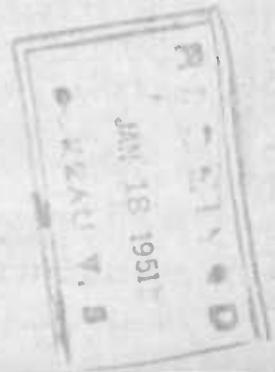
MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
Wicomico		Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place)	
TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		3. NAME OF DECEASED (First) (Middle) (Last)	
Peninsula General Hospital		Harry Elmer Palmer	
4. SEX		5. COLOR OR RACE	
Male		White	
6. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	
Book keeper + Secretary		Married, Divorced, Work down	
10a. FATHER'S NAME		10b. KIND OF BUSINESS OR INDUSTRY	
John D. Palmer		Berlin Bldg. 1, Store	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS		18. MEDICAL CERTIFICATION	
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		19a. DATE OF OPERATION	
Immediate cause		(a) Cerebral Hemorrhage	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last		(b) Cerebral Arteriosclerosis	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		(c) Atherosclerosis Myocardial Insufficiency	
19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 12-21, 1950, to 1-9, 1951, that I last saw the deceased alive on 1-9-1951, and that death occurred at 10:20 P.M., from the causes and on the date stated above.		SIGNATURE (Degree or title) ADDRESS DATE SIGNED	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF	
Burial		1/12/51	
DATE REC'D BY LOCAL REG.		NAME OF CEMETERY OR CREMATORIAL REG. Mary W. Holloway	
24. FUNERAL DIRECTOR		ADDRESS	
Anna L. Busby		Berlin Md.	



Dr. Lynch

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 532

0997

332

1. PLACE OF DEATH COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Ad. Baltimore</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <i>Town</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Town</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Hospital</i>		STREET ADDRESS <i>RD # 2</i>	
3. NAME OF DECEASED (Type or Print) <i>Olivia</i>		4. DATE OF DEATH <i>Jan 27-59</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>		8. DATE OF BIRTH <i>May 2-1886</i>	
9. AGE last birthday yrs. <i>64</i>		10. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Patterson Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>A.</i>	
13. FATHER'S NAME <i>Joseph</i>		14. MOTHER'S MAIDEN NAME <i>Ganey Elliott</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>123-45-6789</i>	
17. INFORMANT <i>M. Shirley Parsons (Wife)</i>			

MARGIN RESERVED FOR BINDING

F, PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18. MEDICAL CERTIFICATION					
10 # 02 Safety Net					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH		
Immediate cause		(a) <i>Hemis Bronchitis</i>	24 hours		
Antecedent cause(s)		<i>Inflammation of both lungs</i>	10 yrs		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b) <i>13b</i>			
		(c) <i></i>			
II. OTHER SIGNIFICANT CONDITIONS					
Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION				
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) OF INJURY	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
m.					

22. I hereby certify that I attended the deceased from Jan. 5, 1961, to Mar. 27, 1961, that I last saw the deceased

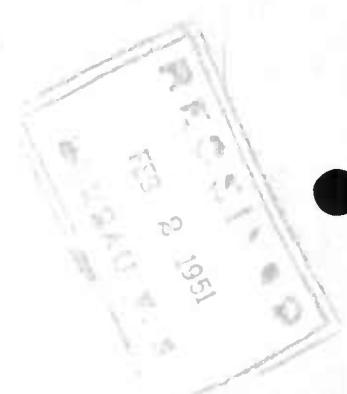
alive on Jan 24, 1951, and that death occurred at 12 noon, from the causes and on the date stated above.
SIGNATURE (Degree or title) **ADDRESS** **DATE SIGNED**

SIGNATURE

ADDRESS

DATE SIGNED

24. BURIAL / CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)	(State)
	Jan. 30-51	Chantilly Cem.	R.D. Salting Inc.	
DATE REC'D BY LOCAL REG.		REG. 1-30-51	REG. MARY W. Holloway	24. FUNERAL DIRECTOR
REG. MARY W. Holloway			Walter R. Holloway	ADDRESS



MARYLAND STATE DEPARTMENT OF HEALTH

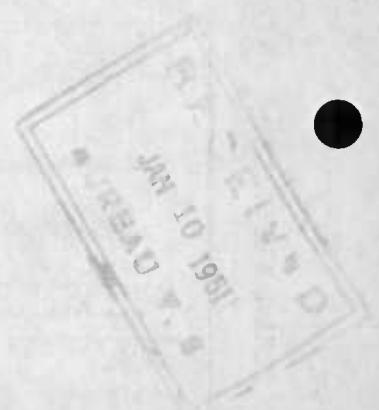
2411 N. Charles Street, Baltimore

0998

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		2. USUAL RESIDENCE (HOME) OF DECEASED CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	
CITY (If outside corporate limits, write RURAL and LENGTH OF STAY (in this place)) HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)	(First) Orlando	(Middle) Chester	(Last) Pollitt
4. DATE OF DEATH	(Month) Jun	(Day) 5	(Year) 1951
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Male	White	Married	March 28-1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Clerk		Building Construction	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
Wardella Md.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John B. Pollitt		Mary Elizabeth Bailey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
		17. INFORMANT AND ADDRESS	
		John Marion J. Pollitt (son)	
18. MEDICAL CERTIFICATION		1106 E. Church St. Salisbury	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Coronary Occlusion (sudden death)	
Immediate cause		(a) _____	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b) _____	
920.1 94a		(c) _____	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, of office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED White at Work m. Not White At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 2:45 P.m., from the causes and on the date stated above.		DATE SIGNED	
SIGNATURE		ADDRESS	
23. BURIAL, CREMATION REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. 1-6-51		REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR		ADDRESS	
		Walter R. Holloway 510246	





Dr. Brile

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY	Wicomico		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)		STREET ADDRESS
TOWN Salisbury			TOWN Salisbury		311. Baker st.
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS		

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH
Male	Albert	Washington	Purcell	Jan. 31 - 51
6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. CITIZEN OF WHAT COUNTRY?
White		Feb. 13-1883	68 yrs.	U.S.A.

10a. USUAL OCCUPATION (Give kind of work done during last 10 years of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salisbury	General Store	Salisbury Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas Purcell	Martha Adams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No.		Mr. Carson B. Purcell (Wife)

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
432.1	Immediate cause	(a) Artherosclerotic gangrene left leg	3 weeks
93d	Antecedent cause(s)	(b) Artherosclerotic arteriosclerosis	14 yrs.
	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) discos	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?		
		Yes <input type="checkbox"/> No <input type="checkbox"/>		
21. ACCIDENT SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 19....., to 19....., that I last saw the deceased alive on 19....., and that death occurred at 9.15 P.m., from the causes and on the date stated above.		
SIGNATURE	ADDRESS	DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORIUM	LOCATION (City, town, or county)	(State)
DATE REC'D BY LOCAL REG. 2-1-51	REGISTRAR'S SIGNATURE	Mary H. Holloway	Holloway & Co.	Salisbury Md.
			Walter K. Holloway	9700 W.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1951

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH CITY OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		1. PLACE OF DEATH CITY (If outside corporate limits, write RURAL and give nearest town) TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS	
Wicomico Maryland		Salisbury 6 days Dover Head State Hospital		Maryland Salisbury 602 Rose Street.	
3. NAME OF DECEASED (Type or Print)		(First) Leroy (Middle) James (Last) Quinton		4. DATE OF DEATH Jan. 19 1951	
5. SEX m		6. COLOR OR RACE e		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 5/2/1897	
unknown		unknown		9. AGE last birthday 53 yrs.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Georgetown		Unknown			
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Georganna Quinton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 217-10-3558			
17. INFORMANT AND ADDRESS Hospital Record		18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Hypertensive cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH unknown	
Immediate cause 026x		(a) Intra cerebral bleeding		~2 mo	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 30c		(b) Extensive nervous system syphilis		unknown	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan. 13, 1951, to Jan. 19, 1951, that I last saw the deceased alive on Jan. 19, 1951, and that death occurred at 2:22 A.m., from the causes and on the date stated above. SIGNATURE ADDRESS DATE SIGNED					
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF 1-23-51		NAME OF CEMETERY OR CREMATORIAL Public Cem	
DATE REC'D BY LOCAL REG. 1-23-51		REGISTRAR'S SIGNATURE Mary W. Holloway		LOCATION (City, town, or county) Salisbury md	
24. FUNERAL DIRECTOR ADDRESS					
Booker M. West					
Salisbury, Md. 20500					



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 386

1002

BE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

1. PLACE OF DEATH COUNTY		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE		COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN		35 yrs		TOWN		Delmar	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		R 70 # 3		STREET ADDRESS		R 70 # 3 (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		(First) MAURICE (Middle) COOPER (Last) REDDISH		4. DATE OF DEATH		(Month) Jan (Year) 1951	
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)		8. DATE OF BIRTH	
Male		White		Married		3-26-1915	
104. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		9. AGE last birthday	
Farming		Farm		Delmar		35 yrs	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY			
Ernest Reddish		Mary Eller		Delmar, Md 232			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS		18. MEDICAL CERTIFICATION	
Yes		97-972		Service Doctor - Delmar			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420. Immediate cause (a) Coronary occlusion							
94a. Antecedent cause(s) (b) Coronary sclerosis							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
21. ACCIDENT SUICIDE HOMICIDE		(Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
INJURY		TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1-1, 1951, to 1-1, 1951, that I last saw the deceased alive on 1-1, 1951, and that death occurred at 9:00 P.m., from the causes and on the date stated above. SIGNATURE ADDRESS DATE SIGNED H.V. Soller, M.D. Delmar, Del. Jan. 3-1951.							
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CINERATORIUM		LOCATION (City, town, or county) (State)	
Orient		1-4-51		M. P. Cemetery		Delmar, Del.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Jan. 4, 1951		Harry Hudson		M. B. Maryland Co. Delmar		1951	

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Dr. Lang

MARYLAND STATE DEPARTMENT OF HEALTH

100.

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH- COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE	
Wisconsin		Md. Wisconsin	
MARYLAND		COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN Salisbury		TOWN Salisbury	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
P.S. Hospital		210, E. Church St.	
(If rural give location)			
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) Roy		(Month) Jan.	
(Middle) Francis		(Day) 16 - 51	
(Last) Reno		(Year)	
5. SEX Male		6. COLOR OR RACE White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH May 12, 1918	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chef		9. AGE last birthday yrs. 85	
10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Haywood, N.C.	
13. FATHER'S NAME John C. Reno		12. CITIZEN OF WHAT COUNTRY U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		14. MOTHER'S MAIDEN NAME Cora Williams	
(If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT Mrs. Annabelle Reno (Wif.)	

MARGIN RESERVED FOR BINDING

THE CORRECT AGES
ARE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct ages is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1004

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <i>Worcester</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>MARYLAND</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Salisbury, Maryland</i>		LENGTH OF STAY (in this place) <i>6 hrs.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Peninsula General Hospital</i>		STREET ADDRESS <i>RFD #12</i>	
3. NAME OF DECEASED (Type or Print) <i>George</i>	(First) <i>Alma</i>	(Middle) <i>Rolls</i>	(Last)
4. DATE OF DEATH <i>January 15</i>	(Month) <i>1951</i>	(Day) <i>15</i>	(Year)
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>June 27 1888</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Life Ins. Agent</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	9. AGE last birthday <i>62 yrs.</i>	If under Montha Year Days Hours Min.
11. BIRTHPLACE (State or foreign country) <i>Perry Missouri</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	13. FATHER'S NAME <i>Edgar D. Rolls</i>	
14. MOTHER'S MAIDEN NAME <i>Maryelle Bell</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>Yes World War I</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT AND ADDRESS <i>Mrs. George D. Rolls Berlin MD</i>
18. MEDICAL CERTIFICATION B 1/2 INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
443x 93d	Immediate cause <i>Hyperensive Cardiovascular</i>	(a) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>With acute Cardiac dilatation</i>	(b) (c)
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Arteriosclerosis</i>			
19a. DATE OF OPERATION <i>None</i>	19h. MAJOR FINDINGS OF OPERATION <i>✓</i>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE <i>None</i>	(Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <i>None</i>	(CITY OR TOWN) <i>(None)</i>	(COUNTY) <i>(None)</i>
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>None</i>	INJURY OCCURRED While at Work m. Not While At work <i>None</i>	HOW DID INJURY OCCUR? <i>(None)</i>	
22. I hereby certify that I attended the deceased from <i>Jan 14, 1951</i> to <i>Jan 15, 1951</i> , that I last saw the deceased alive on <i>Jan 14, 1951</i> , and that death occurred at <i>9:10 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>Patricia M. Holloway</i> (Degree or title) <i>220 Caedus Ave Salisbury MD</i> ADDRESS DATE SIGNED <i>1-16-51</i>			
23. BURIAL, Cremation REMOVAL (Specify) <i>None</i>	DATE THEREOF <i>1-18-51</i>	NAME OF CEMETERY OR CREMATORIAL <i>Buckingham</i>	LOCATION (City, town, or county) <i>Berlin MD</i>
DATE REC'D BY LOCAL REG. <i>1-18-51</i>	REGISTRAR'S SIGNATURE <i>Maryelle Holloway</i>	24. FUNERAL DIRECTOR <i>None</i>	ADDRESS <i>George A. Bubba Berlin MD</i>



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

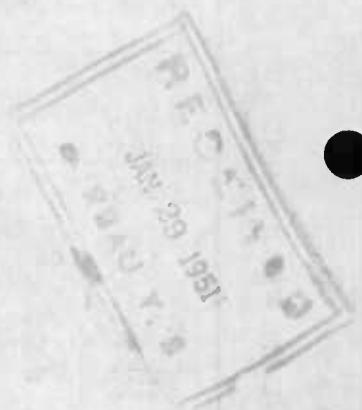
2411 N. Charles Street, Baltimore

1005

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS	
Wicomico Salisbury Deer's Head State Hosp.		Maryland Snow Hill (If rural, give location)	
3. NAME OF DECEASED (Type or Print) Edward		4. DATE OF DEATH Jan. 25 1951	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH Oct. 31, 1868
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Jenkins Timmons		11. BIRTHPLACE (State or foreign country) Maryland Berlin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS Hospital Record	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 443X Immediate cause 93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (a) Hypertensive Cardiovascular disease (b) (c) Arteriosclerosis, General Aspiration pneumonia			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 9 days			
21. ACCIDENT SUICIDE HOMICIDE TIME (Month) (Day) (Year) (Hour) OF INJURY		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY While at Work <input type="checkbox"/> At work <input type="checkbox"/>	(CITY OR TOWN) How did injury occur?
22. I hereby certify that I attended the deceased from alive on <u>Jan. 25</u> , 1951, and that death occurred at <u>2:58 A.M.</u> , from the causes and on the date stated above. SIGNATURE <u>Asel G. Paar, M.D.</u> ADDRESS <u>Deer's Head State Hosp., Salisbury, Md. 12551</u> DATE SIGNED <u>1951</u>			
23. BURIAL, CREMATION REMOVAL (Specify) DATE REC'D BY LOCAL REG.		DATE THEREOF Jan. 26/51	NAME OF CEMETERY OR CREMATORIAL Whitcroft
24. FUNERAL DIRECTOR REG.		ADDRESS Elmer B. Morris, Jr., M.D.	



Evidence for addition
of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Film No. G 130 JAN 16 1951 C

CERTIFICATE OF DEATH

Reg. Dist. No.

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1. PLACE OF DEATH COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Salisbury		LENGTH OF STAY (in this place) 14 days 16 hrs		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore		(If rural, give location) 107 N. Bond St.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer's Head		STREET ADDRESS		STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)	(First) Joseph	(Middle) Thomas	(Last) Toomer	4. DATE OF DEATH	(Month) 1	(Day) 4	(Year) 1951
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH	9. AGE last birthday 54 yrs.	10. If under 1 year Months	11. If under 24 hrs Days	12. If under 24 hrs Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salvage		10b. KIND OF BUSINESS OR INDUSTRY Ind.		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Toomer, Joseph		14. MOTHER'S MAIDEN NAME Williams, Hennie		15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 74	
17. INFORMANT AND ADDRESS Hospital Record		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
43X Immediate cause Hypertensive cardiovascular disease		(a) Hypertensive cardiovascular disease		61 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause Arteriosclerosis General		Unknown	
61 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause Arteriosclerosis General		(b) Arteriosclerosis General		61 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause Arteriosclerosis General		Unknown	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus, uncontrolled.		III. MAJOR FINDINGS OF OPERATION Diabetes mellitus, uncontrolled.		IV. DATE OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12/20 , 1950, to 1/4/51 , 1951, that I last saw the deceased alive on Jan. 4 , 1951, and that death occurred at 6:22 A.M. , from the causes and on the date stated above. SIGNATURE Aspel C. Paas, M.D. ADDRESS Deer's Head Hotel, Salisbury, Md. DATE SIGNED 1/4/51							
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 1-7-51		NAME OF CEMETERY OR CREMATORIAL Mt. Calvary Cem.		LOCATION (City, town, or county) (State) Brookline, Md.	
DATE REC'D BY LOCAL REG. 1-9-51		REGISTRAR'S SIGNATURE Mary W. Holloway		24. FUNERAL DIRECTOR Elroy S. Wilson, 1000 Bratt St.,		ADDRESS Baltimore, Md.	

PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

A MARGIN RESERVED FOR BINDING

V5 A15



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1951

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH CITY TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED CITY TOWN STREET ADDRESS	
County Wicomico Salisbury Peninsula General Hospital		Maryland Salisbury Delaware Street	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
James C. Newlin		January 23, 1951	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Male	Cloud	Married	1961
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Laborer, factory.		None	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Unknown		Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		218-24-7501	
17. INFORMANT AND ADDRESS		18. MEDICAL CERTIFICATION	
218-24-7501 Flora Vangerson		Metastatic Carcinoma Carcinoma of Prostate Gland	
19a. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause 177 Antecedent cause(s) 51b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(a) (b) (c)	
19b. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE TIME (Month) (Day) (Year) (Hour) OF INJURY		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY While at Work <input type="checkbox"/> At work <input type="checkbox"/> m.	
		(CITY OR TOWN) (COUNTY) How did injury occur?	
22. I hereby certify that I attended the deceased from <u>Nov.</u> , 19 <u>50</u> , to <u>Jan. 23, 1951</u> , that I last saw the deceased alive on <u>Jan. 23, 1951</u> , and that death occurred at <u>8:07</u> a.m., from the causes and on the date stated above. SIGNATURE <u>Leech R. Flame M.D.</u> ADDRESS <u>Salisbury, Md.</u> DATE SIGNED <u>Jan. 23, 1951</u>			
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF NAME OF CEMETERY, OR CREMATORIAL LOCATION (City, town, or county) (State)	
DATE REC'D. BY LOCAL REG.		REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS	



MARYLAND STATE DEPARTMENT OF HEALTH

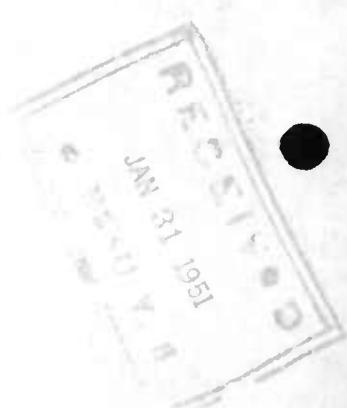
2411 N. Charles Street, Baltimore

1968

CERTIFICATE OF DEATH

Reg. Dist. No. 332

I. PLACE OF DEATH: COUNTY <i>Malvern</i>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Md.</i> COUNTY <i>Malvern</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Sabiney</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Sabiney</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>P.S. Hoyt</i>		STREET ADDRESS <i>323 E. Nine st.</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>Thomas</i> (Middle) <i>Walter</i> (Last)	4. DATE OF DEATH <i>1968</i>	(Month) <i>Jan.</i> (Day) <i>27</i> (Year) <i>68</i>
5. SEX <i>Male</i>	6. COLOR OF RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Nov. 1917</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labourer</i>	10b. KIND OF BUSINESS OR TRADE <i>Food Distributor</i>	11. BIRTHPLACE (State or foreign country) <i>Clearance Md.</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
13. FATHER'S NAME <i>Thomas Walter</i>	14. MOTHER'S MAIDEN NAME <i>Louise Boyman</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mr. Cora E. Walter (wife)</i>	18. MEDICAL CERTIFICATION <i>Acute cardiac failure (asthmatic) 1 day</i>
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		19. MEDICAL CERTIFICATION <i>Benign hypertrophy prostate.</i>	
Immediate cause <i>610X</i>	(n) <i>Acute cardiac failure (asthmatic) 1 day</i>	INTERVAL BETWEEN ONSET AND DEATH	
Antecedent cause(s) <i>137as</i>	(b) <i>Benign hypertrophy prostate.</i>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>(c)</i>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <i>12-18-50</i>	19b. MAJOR FINDINGS OF OPERATION <i>Benign hypertrophy prostate.</i>	20. AUTOPSY? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>X</i>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, of office bldg., etc.) <i>Parson Am.</i>	(CITY OR TOWN) <i>Sabiney</i>	(COUNTY) <i>Malvern</i>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>12-18-50</i> , 19 <i>50</i> , to <i>1-27</i> , 19 <i>51</i> , that I last saw the deceased alive on <i>1-26</i> , 19 <i>51</i> , and that death occurred at <i>8:17a</i> m., from the causes and on the date stated above.			
SIGNATURE <i>Stacy a. Tandy</i>	(Degree or title) <i>Parson Am.</i>	ADDRESS <i>Sabiney Md.</i>	DATE SIGNED <i>1-29-51</i>
23. BURIAL, CREMATION, DATE REMOVAL (Specify) <i>Parson Am. Jan. 29-51</i>	NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) <i>Sabiney</i>		(State) <i>Md.</i>
DATE REC'D BY LOCAL REG. <i>1-29-51</i>	REG. <i>1-29-51</i>	REGISTRAR'S SIGNATURE <i>Mary W. Holloway</i>	24. FUNERAL DIRECTOR <i>Holloway & Co. Sabiney Md.</i>
			ADDRESS <i>Walter R. Holloway 970 698</i>



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1009

CERTIFICATE OF DEATH

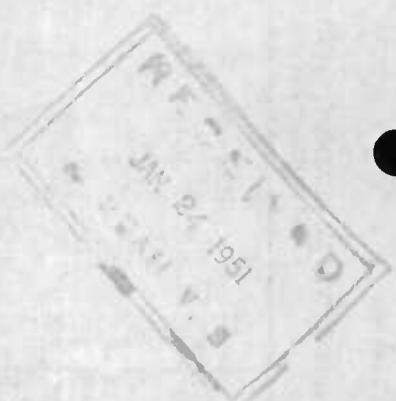
Reg. Dist. No. 332

1. PLACE OF DEATH: COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>MARYLAND</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Salisbury</i>		LENGTH OF STAY (in this place) <i>9 days</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Deer's Head State Hosp</i>		3. NAME OF DECEASED (First) <i>Reuben</i>	
		(Middle) <i>Vaughn</i>	
		(Last) <i>Wheatley</i>	
4. DATE OF DEATH <i>Jan. 18</i>		(Month) (Day) (Year) <i>Jan. 18 1957</i>	
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>unavailable</i>		8. DATE OF BIRTH <i>Jan. 28, 1869</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>invalid</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>unavailable</i>	
11. BIRTHPLACE (State or foreign country) <i>Galestown</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Silas Wheatley</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Vaughn</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>unknown</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>unavailable</i>	
17. INFORMANT AND ADDRESS <i>Hospital Record</i>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause (a) <i>Trombosis of right middle cerebral artery (recurrent)</i> INTERVAL BETWEEN ONSET AND DEATH <i>14 yrs.</i> Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Jan. 9</i> , 1951, to <i>Jan. 18</i> , 1957, that I last saw the deceased alive on <i>Jan. 18</i> , 1957, and that death occurred at <i>11:45 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>Reuben A. Vaughn M.D.</i> ADDRESS <i>Deer's Head State Hosp, Salisbury, Md. 1/18/57.</i> DATE SIGNED <i>1/18/57</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>burial</i>		DATE THEREOF <i>1/21/57</i>	
DATE REC'D BY LOCAL REG. <i>1-20-57</i>		NAME OF CEMETERY OR CREMATORIAL REG. <i>Deer's Head State Hosp, Salisbury, Md.</i>	
24. FUNERAL DIRECTOR REG. <i>Mary W. Holloway</i>		ADDRESS <i>Paul J. Smith, Chesapeake, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1019

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <i>Wisconsin</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Head - o - the - Creek all life</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Head - o - the - Creek</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>at home</i>		STREET ADDRESS <i>P. O. address Quantico, Md. Rt. #1</i>	
3. NAME OF DECEASED (Type or Print) <i>Robert</i>	(First) <i>Robert</i>	(Middle) <i>Fulton</i>	(Last) <i>Wilson</i>
4. DATE OF DEATH <i>1 - 3 - 1951</i>	(Month) <i>1</i>	(Day) <i>3</i>	(Year) <i>1951</i>
5. SEX <i>male</i>	6. COLOR OR RACE <i>a a</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>married</i>	8. DATE OF BIRTH <i>1 - 20 - '03</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>merchant</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>own store</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland Wisconsin Co.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Samuel Benjamin Wilson</i>	14. MOTHER'S MAIDEN NAME <i>Annie Eliza Jones</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>	16. SOCIAL SECURITY NO. <i>no</i>
17. INFORMANT AND ADDRESS <i>Mrs. Juanita Wilson, Quantico, Md. Rt. #1.</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
331x Immediate cause	(a) <i>Cerebral Haemorrhage</i>		
83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <i>Hypertension</i>		
	(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>INJURY</i>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from , 19....., to , 19....., that I last saw the deceased alive on , 19....., and that death occurred at m., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED <i>Ezra G. Mawman</i> <i>Princess Anne road</i> <i>Dec 9 51</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>1-12-51</i>	NAME OF CEMETERY OR CREMATORIAL <i>Church Cemetery Head - o - the - Creek</i>	LOCATION (City, town, or county) (State) <i>Head - o - the - Creek - Wisconsin Co., Md.</i>
DATE REC'D BY LOCAL REG.	REG.	REGISTRAR'S SIGNATURE <i>Mary W. Holloway</i>	FUNERAL DIRECTOR ADDRESS <i>James B. Sashill Salisbury Maryland</i>
2905 86			



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

1911
Reg. Dist. No. 335

1. PLACE OF DEATH CITY TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE CITY TOWN STREET ADDRESS		
Wicomico MARYLAND Smyrna, Md.		MD Wicomico Smyrna WANTICOKE ST		
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH		
Tightman		JAN 14 1957		
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	
Male	White	Single	Sept 18 1891	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Lumber		Lumber	Md	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
Perry Wright		Elizabeth Ann Welling		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT	
		215-07-5028	Mo. Sia Sicker	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				sudden
420.1 Immediate cause		(a) Coronary Disease		
Antecedent cause(s) 940		(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c)				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input type="checkbox"/> at work <input type="checkbox"/>		HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .				
SIGNATURE		(Degree or title)		DATE SIGNED
23. BURIAL, CREMATION OR REMOVAL (Specify)		DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county) (State)
Burial		1/17/51	Elmwood	Shapley Rd
DATE REC'D BY LOCAL REG.		REG. 1/16/51	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
			Walter G. Mann	Paul J. Smith Shapley Rd 970 305

MARGIN RESERVED FOR BINDING

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